

Confidential Patient Information

In order for us to understand your health problems, please complete the form below. After review and examination, if we do not sincerely believe your problem will respond favorably to chiropractic care, we will not accept your case. We will refer you to a specialist we believe will help you. Thank you for selecting Chiropractic Professional Center as part of your health care team.

Patient Name _____ Date _____
Age _____ Date of Birth _____ Email address _____
Address _____ City _____ State _____ Zip _____
Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____
Occupation _____ Employer _____
Address of Employer _____ City _____ State _____ Zip _____
Marital Status: Single Married Widowed Divorced Children: Yes No Ages: _____
Emergency Contact _____ Relation _____ Phone (_____) _____
Spouse _____ Spouse's Occupation _____
Spouse's Employer _____ Business Phone (_____) _____
Present Family Doctor _____ Phone & Address _____

WHAT IS YOUR CURRENT PROBLEM OR CONDITION? _____

When did this problem start? _____

How did it start? _____

Have you ever had similar problems before? Yes No If yes, when? _____ If yes was it Sudden or Gradual?

Did you have an accident? Yes No If yes: Auto Accident Work-related accident Other _____

Have you lost days from work? Yes No If yes, how many days? _____

What makes it worse? _____ What makes it better? _____

Type of Pain: Sharp Dull Achy Burning Shooting Throbbing Stabbing Other _____

Intensity of Pain: Mild Moderate Strong Severe Do you experience shooting pain to any parts of your body?

Where do you hurt? _____

Is the pain or discomfort: Constant Occasional How frequently does it occur? _____

How long does it last? _____ Is your condition: Getting Better About the Same Getting Worst

Do you have increased pain during: Coughing Sneezing Bowel movements None of these

Any change in the daily functions? Digestion Vision Breathing Urination Defecation Sexual Other _____

WHAT MEDICATIONS ARE YOU TAKING? _____

Have you seen other doctors for this condition? _____

Have you had any treatment, x-rays, MRI, or other test in your areas of complaint? Yes No

If yes where and when? _____

Do you have any previous chiropractic care? Yes No

If yes what were the results? _____

Why do you think chiropractic care could help you? _____

How serious do you perceive your problem? _____

What other steps have you taken to solve this problem? _____

What is your theory about why the steps did not work? _____

(OVER)

How long do you think it will take to get the results you want? _____

What has your lack of health prevented you from doing or enjoying? _____

Have you ever had any of the following conditions: N (No) Y (Yes)

- | | | | |
|-------------------------|-------------------------|--------------------------|-------------------|
| ___ Headaches | ___ Cancer | ___ TIA's (mini strokes) | ___ Backache |
| ___ Neck aches | ___ Blood thin meds | ___ Pace maker | ___ Sciatica |
| ___ Dizziness | ___ Uterine fibroids | ___ Diabetes | ___ Muscle spasm |
| ___ Visual disturbances | ___ High blood pressure | ___ Asthma | ___ Hernia |
| ___ Oral contraceptives | ___ Heart trouble | ___ Allergies | ___ Kidney stones |
| ___ Migraines | ___ Rheumatic fever | ___ Anemia | ___ HIV |
| ___ Arthritis | ___ Stroke | ___ Digestive disorder | ___ Other _____ |
| ___ Neuritis | ___ Arteriosclerosis | ___ High cholesterol | |

Broken Bones _____ Surgeries/ Hospital stays _____

Major accidents or Injuries _____

Women only: Any chance you could be pregnant? ___ Date of last menstrual cycle: _____ Date of last Pap-Smear: _____

Men only: Date of last PSA (Prostate Specific Antigen): _____

YOUR HEALTH HABITS: Do you take vitamin supplements? Yes No Type: _____

How much do you drink:

Do you regularly eat:

- | | | | | | |
|-----------|------------------|-----------------|------------------|-----------------|-----------------------|
| Water ___ | Coffee/Soda ___ | Red meat ___ | Sugary foods ___ | Fast food ___ | Grains/Beans ___ |
| Milk ___ | Alcohol/Beer ___ | White meats ___ | Salty foods ___ | Snack foods ___ | Fruits/Vegetables ___ |

Do/ did you ever smoke? Yes No If yes, how many packs per day? _____ If yes for how long? _____

Do you exercise? Yes No If yes what type? _____ If yes how frequently? _____

What is your usual sleep position? Back Stomach Right side Left side Toss/turn

How many hours per night do you sleep? _____

What type of pillow do you use? _____ How many pillows do you use? _____

How old is your mattress? _____ Is your mattress: Firm Medium Soft Other _____

Do you use Orthotics (customized shoe inserts)? Yes No If yes for how long? _____

Please check you occupational duties: Prolong standing Prolong sitting Bending/ twisting Lifting Typing
 Computer work Driving Writing Physical labor Other _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance company and this office. I authorize this clinic to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company. **If my condition is a regular health insurance case, then I agree to pay a percentage of services as they are rendered and any deductible or co-payments that are required.** However, I understand that I am responsible for payment in full at this office. In case my account goes to collection an automatic \$36.00 processing fee will be added to my balance. **I also agree not to raise the Statue of Limitation as a defense.** In addition if my balance due is over 90 days a rate of 1.5% per month will be added to my balance. I also understand that I will be responsible for the attorney's fees in the amount of 15% of the balance due.

HEALTH INSURANCE: YES NO COMPANY: _____

PATIENT'S SIGNATURE: _____ DATE: _____

(OVER)